Toxic Care (?)
Scepticism and Treatment Failure in Post-Soviet Mongolia

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Abstract

In post-socialist Mongolia, unsuccessful treatment, or worse, interventions that result in worsened health conditions, are common concerns. Patients and clients direct scepticism towards a range of practitioners, from biomedical physicians to shamans and 'folk' healers (*domch*). The gap between the ideal treatment and the actual outcome—the prevalence of treatment misfires—invites analysis of infrastructural changes to (health)care and wider contexts of relationality. As state-owned medicine was restructured in the 1990s, healing 'traditions' such as shamanism and Traditional Mongolian Medicine considered essentialised aspects of national identity have gained new legitimacy. Many people find it challenging to navigate the multiple authorities on health and wellbeing that exist in contemporary public. Patients and clients often questioned efficacy in terms of toxicity and poison (*hor, horlol*). Toxicity's associations with Soviet-era regulation and Buddhist medical contexts articulate the importance of both state-sanctioned regulation and the practitioner's specialised knowledge.

Keywords

care – post-socialism – medical infrastructure – failure – scepticism – toxicity – poison – healing – shamanism – 'folk' medicine – Soviet medicine – Traditional Mongolian Medicine

'What century are we living in? If it was the eighteenth century I would go to an enlightened lama (*khuvilgaan*) to heal. But we have modern medicine!'

A Mongolian friend relayed the experiences of her cousin who had recently been misdiagnosed by an enlightened lama, a healer who claims to 'see inside the human body several times better and faster than scientific apparatuses'. This enlightened lama runs two bustling in-patient clinics of approximately 60 beds each, amassing a following of some thousands of former patients and devotees over the past several years. He offers what many consider affordable, non-invasive treatment, much of it loosely based on traditional medicine. Referring again to her cousin: 'She wasted money and time while her stomach cancer worsened', my friend paused to note: 'It could have been much worse for her. You need to be careful visiting people like this. You can get poisoned (*horlogdoh*).' I had heard accounts before of this kind: lay

people who attend shamanic rituals and make themselves vulnerable to spiritual poisoning by asking personal questions. A poisonous spirit (*horloliin süns*) followed an interlocutor home from one such seance and haunted her bedroom for a month until finally, terrified and unable to sleep, she called in a different shaman to chase the poisonous spirit away with her drum, song and a spray-bottle filled with vodka.

In this article I address the ambivalence with which many approach healing and medical treatment in contemporary Mongolia. It is difficult to know what kind of care one is receiving and often it does not become clear—if ever—until after treatment. Widespread scepticism circulates, not just in terms of 'alternative' therapies such as shamanism, but including state-sponsored and privately owned biomedical clinics. During 20 months of doctoral fieldwork (2014–2016) exploring medical pluralism in Mongolia, many healers and medical practitioners stressed to me the importance of skill, good intentionality and compassion in guiding the treatment towards efficacy. The gap between the way treatment ought to go and the actuality—the prevalence of treatment misfires—invites analysis of the structural changes to (health)care and public life in post-socialist Mongolia. The past few decades have witnessed an upsurge in the types of practitioners that tend to wellbeing in public life, ranging from individually practising fortune-tellers (*zurhaich*) or energy healers (*bio energich*) to corporations and unions (*holboo*) of shamans, academies that teach astrology and traditional massage, and medical universities dedicated to training physicians in Traditional Mongolian Medicine. The multiple authorities on health and wellbeing have created challenges in treatment assessment: who is responsible for evaluating efficacy? It has also led to a base level of anxiety: should my child take multi-vitamins? Is my neighbour poisoning me with malicious gossip (*hel am*)?

This article follows the recent call in medical anthropological literature to disaffiliate care from its typical associations with positive outcomes, good intentions and sentimental responses to suffering (Aulino 2012; 2016; Garcia 2010; Han 2012; Stevenson 2014: 177). As Aulino (2016) illustrates, care for many Thai people is more about 'rituals of care' than any certain internal conviction such as sincerity. Garcia (2010) traces the sustained intimate and genealogical ties in the lives of heroin users in northern New Mexico, demonstrating the ways in which relationships are maintained through everyday forms of care within addicted families. In one sense acts of 'gifting' heroin to kin in times of physical need and economic scarcity represent 'criminal, perverse or self-defeating' acts, Garcia (2010: 9) maintains, but in another sense they are expressions of care. Divorcing the affective labour of care offered by healers and medical practitioners in Mongolia from its typical associations with good intentions and positive outcomes not only allows for 'the messiness of our attempts to care' (Stevenson 2014: 3) to come into focus, but also the messiness fundamental to the restructuring of (health)care after state socialism more broadly.

When considering the multiple levels upon which infrastructures operate, especially the ways in which they can 'emerge out of and store within them forms of

desire and fantasy' (Larkin 2013: 329), one is afforded particular insight into modernist notions of social progress inherent to the project of Soviet medicine. Idealised versions of medical care aimed at improving the corporeal condition would also advance society at large. However, in what ways and to what extent has contemporary Mongolian society inherited the legacy of Soviet imperial influence with respect to medical care, its infrastructure and social norms concerning health and wellbeing? Stoler's notion of recursive analytics is useful in addressing this question. History as recursion for Stoler (2016: 26) is 'marked by the uneven, unsettled, contingent quality of histories that fold back on themselves and in that refolding, reveal new surfaces and new planes'. Histories as 'processes of partial re-inscriptions, modified displacements, and amplified recuperations' (2016: 27), in the case of post-Soviet health(care) in Mongolia, allow for a particular vantage point from which to understand the ethnographic prevalence of failed treatments and widespread scepticism. When relations among people, things and systems produce something other than intended, certain visibilities are mobilised (Carroll *et al.* 2018). This article explores the micro-fissures and ruptures in the idealised and objectified version of (health)care, contending that characterisations of toxicity and poison (*hor*) not only express contemporary scepticism, but articulate the need for practitioner's specialised knowledge and state-sanctioned safety regulation, as the term carries the weight of associations with Buddhist medicine and Soviet-era safety regulation.

Post-Soviet Health(care) and the Institutionalization of Mongolian Healing 'Traditions'

Although, until the early 1920s, medicine practised in Mongolia was dominated largely by Tibeto-Mongolian medicine 'officially' administered by specialised Buddhist lamas (*otoch maaramba*), the conversion to Soviet medicine in the mid to late 1920s was rapid and thorough. The varied medical technologies available at that time, from obstetrics to antiseptics, surgical procedures to antibiotics, 'inspired faith in the power of socialist medicine' (Bashkuev 2016). Soviet medicine spread with the intention of reaching every village and home, with physicians and nurses engaged as 'clients of the state' (Bernstein *et al.* 2010: 3) in an expansive biopolitical project that represented an integral part of a larger campaign to 'modernise' the country. In Mongolia, this took place at an 'unparalleled pace', as one historian explained to me, 'and in this way we began to prepare our nation's doctors (*ündesnii emchnar*)'. By 1963, Mongolia had 90 hospitals and 1140 doctors (Rossabi 2005: 167), and in the ensuing decades Mongolians enjoyed widespread access to (sometimes very) basic medical services throughout the country. Underpinning the development of medical infrastructure in Mongolia was an enduring commitment to modernist ideology. Social progress under the Soviet agenda was inextricably tied to corporeal health, as the health of the individual became 'a metaphor for that of the body politic, effectively linking the bodies of individuals to the political project of socialism' (Brotherton 2012: 6). Soviet hygiene campaigns, largely speaking, were cast as

educative, intended to uproot bad habits and immoral actions that led to unproductivity and disease as 'hygiene became part of an all-encompassing ideology of enlightened Soviet behavior' (Starks 2008: 7). In Mongolia, these took place in at least two distinct 'culture campaigns', proclaimed by the socialist government in 1960–61 and 1962–63 to eradicate illiteracy, alcoholism, epidemics and vandalism (Steiner-Khamsi & Stolpe 2006: 193).

Restructuring of medical care as part of the package of neo-liberal reform known as 'shock therapy' precipitated severe decline in health in the 1990s and early 2000s. Much of the problem stemmed from insufficient government funding, lack of medical equipment and training, and the inability of many to afford the fees now associated with healthcare, such as ambulance cost, blood tests and physical examinations (see Rossabi 2005: 167–74). In conjunction with the Asian Development Bank, in 1998 the Ministry of Health established a subsidised pay-for-service model based on health insurance that is still used today. Ulaanbaatar and the country's 21 provinces are subject to a two-tiered referral system: primary care and specialised care (including secondary and tertiary care). Primary care is free of cost, while secondary care requires 10 per cent co-payment and tertiary a 15 per cent co-payment (World Health Organization 2012).

With respect to neoliberal reform, I join recent academic interest in problematising state 'withdrawal' models (Read & Thelen 2007) and characterisations of a monolithic neo-liberal state (Dunn 2008). As opposed to a 'wiping away through calculated choice existing forms of Soviet social welfare', a focus on the materiality of infrastructures—on pipes and valves, hospital buildings and budgets—allows instead for considering post-Soviet neoliberal reform as a 'selective reconfiguration of inherited material structures, demographic patterns and social norms' (Collier 2011: 3).

Repatterning of Soviet material structures and social norms related to (health)care has led to the institutionalisation of 'traditional' healing practices such as Traditional Mongolian Medicine and shamanism (*böö mörgöl*), lending them new legitimacy. This can be seen in the incorporation of traditional medicine in mainstream medical school curricula, into each of the six national sanatoria (*rashaan suvilal*) and countless smaller ones constructed for agricultural collective (*negdel*) usage, and the widespread mixing of traditional medicine with biomedical treatments in many of the 1184 private hospitals and clinics in the country in 2011, dramatically increased from the 683 in 2005 (World Health Organization 2012).

In considering the partial inheritance of Soviet-era social norms, the ethno-nationalism that was a component of Soviet modernist vision[1] can be traced to the

[1] In many ways, the prototype for ethnoregional nationalism seen across postsocialist Central Asia and elsewhere was in part created by Lenin's indigenisation (*korenizatsiia*) policy, the literal translation of which bears something like 'root-ification'. Although the centre denied borderland ethnorepublics the right to self-determination, as Moscow granted a minimal

robust construction of 'national culture' in Mongolia over the past several decades. Such nationalist sentiment has led to the institutionalisation of certain healing practices considered 'traditional'. Intangible cultural heritage, in large part derived from the Soviet notion of 'intellectual culture', has been integral to the acquisition and maintenance of international recognition of independent nationhood (Tsetsentsolmon 2014). As early as 1974 and by way of conferences and the founding of research institutes, UNESCO has been involved in popularising the notion of a Mongolian nomadic civilisation, tracing its inception to increasingly ancient origins in cultural continuity with contemporary society (Tsetsentsolmon 2014: 432). Shamanism has played an important role in the construction of national culture, as it has been considered the foundational religion of Mongolia's uniquely 'nomadic civilisation', beginning in academic circles and spreading to public life more generally (Bumochir 2014). This has led to the incorporation of shamanism into medical infrastructure, even if by informal and less centralised means. For example, reports circulate of a steady stream of unsuccessfully treated patients at the National Centre for Mental Health that are sent to rural Dornod province to be treated by the son of a famous shaman, himself amassing a large following of disciples and devotees. In 2014, the district board (*horoo*) in one of Ulaanbaatar's *ger* districts offered Buyankhishig, a shamanness (*udgan*), a consultation room in the local family health centre (*örhiin emneleg*). Buyankhishig was offered a salary of over 100,000 *tögrög* per month with the stipulation that she would not be able to accept payments directly from patients. She declined the offer, figuring that she could earn more working out of the ritual *ger* adjacent to her home.

As 'an artifact of post-socialist nation-building' (Janes & Hilliard 2008: 39), Traditional Mongolian Medicine (TMM) represents a second example of institutionalisation of the nation's healing traditions. In the early 1990s, TMM was reconstructed from the legacy of pre-1921 Tibeto-Mongolian medicine by several Mongolian biomedical physicians trained in an assortment of pan-Asian medicines. Janes and Hilliard (2008) trace the reconstruction of TMM to the severe decline in the

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amount of political agency to local party-state operations in charge of their own union republics, 'a degree of localism was tolerated' so long as nationalism did not enter into official political agendas (Smith *et al.* 1998). Throughout the post-Stalinist years, local politicians were allowed to promote the economic interests and needs of their own republics as long as such policies did not undermine the authority and vision of leaders in Moscow. Examples here include 'affirmative action' plans of fast-tracked upward mobility among natives within their own national homelands to positions of power in politics, intelligentsia, academia and the Communist Party—in effect, the indigenisation of local (elite) leadership (see Martin 2001). This type of nation-building encouraged the ethnorepublic to be seen as the 'identity-marker' of their home space, which represented a major difference between Soviet identity in the Russian Federation *versus* borderland republics (Smith *et al.* 1998: 6).

health of the Mongolian population amid the economic crisis of the 1990s, and the efforts of biomedical physicians to train in alternative medicine in Korea, Tibet and China in order better to serve Mongolia's ailing population. In consultation with international donors and policy-makers, the Mongolian government targeted primary care as the focal point of healthcare reform, promoting limited training in TMM for primary care physicians as a marketable, efficient and complementary component to healthcare delivery.

Reconfiguration of inherited Soviet infrastructure, practices and social norms concerning medicine and healing has meant new associations for non-biomedical healing practices with public life, despite maintaining similar 'modes of relationality' (Rivkin-Fish 2005). In Soviet-era Mongolia, 'traditional' healing practices were officially banned as 'superstition' (*muhar süseg*), yet practised secretly (*dalduur*). Such practices existed in the private sphere, outside the official gaze of the state, heavily relying upon networks of relation and informal economy of favours.[2] For instance, 'elderly people who knew about the matter'[3] brought a shaman interlocutor living in Khövsgöl province to their homes during the night in order to 'have them separate from illness and suffering by ritual'.[4] A practitioner of massage (*bariach*) was taught at age 10 by her aunt living in Ulaanbaatar. Within two years she became locally well known:

> Then people knew about me. They began to call me 'Tuya *bariach*'. It was 1971, 72 at that time. Outside of my aunt's apartment so many cars stopped like an office. One car stopped, was massaged, and left. The next car came and was massaged. People said, 'this is Ganaa's disciple. Let's get massaged by her'. […] They gave me 3 *tögrög* or 5 *tögrög*. This was a lot of money back then.[5]

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2 As opposed to western notions of private that entail both civil society and personal life, the socialist state offered no officially recognized space in which an autonomous civil or political society could emerge (Garcelon 1997). People relied on personal, often extended kin-based networks to gain access to goods and services in short supply that were largely hidden from the pervasive gaze of the state (Ledeneva 1998; Verdery 1996). Such informal personal relations have come to be considered the 'private' during state socialism (Pine 2002).

3 *nastai uchir meddeg hümüüs*

4 *övchin zovlongoos salguuj arag zasal hiilegdeg*

5 *Tegeed hümüüs namaig medchihsen. 'Oh ene Tuya bariach' gej heldeg bolson. Ter üyed 71, 2 onii üye. Tegeed manai egchiin gadaa alban gazar shig aimaar ih mashiin ireed zogchihdog baisan. Neg mashiin zogsood, bariuulaad yavna, daraa ni nogoo mashiin ireed bariuuldag baisan. 'Oh ene nogoo Ganaagiin shavi baisan. Enuugeer bariuliy gedeg baisan'. […] Tedgeed nadad 3 tögrög, 5 tögrög ögdög. Ene möngö ter üyed ih möngö baisan.*

Tuya tried to hide the practice from her parents, but before long 'people themselves came to my father and asked, "let's have your daughter give a massage".'[6]

Such practices have increased in popularity since the mid 1980s and become salient aspects of public life, yet maintain an affective 'mode of acting' (Henig & Makovicky 2017) based on informal networks of relation reminiscent of the private during the state socialist period. For the majority of such practitioners today, it is uncommon to set a fixed price or advertise for oneself: 'People just recommend me' (*zügeer l hümüüs tegej sanal tavidag*), as one practitioner of massage (*bariach*) succinctly stated. For many Mongolians, non-biomedical treatments represent viable options for meeting the needs of their health and wellbeing within a larger medically pluralistic field,[7] especially when biomedical options are deemed too expensive, over-invasive or not trustworthy, points that will be addressed in the following section. A different *bariach* summed this up well: 'If you injure a bone and go to the hospital they perform an operation. But in my opinion you don't need this. I can heal it slowly, by massage. But at the hospital, they will perform an operation that costs 3 million *tögrög'*.[8]

In this section I have argued that the restructuring of Soviet medical infrastructure and related social norms has accommodated the institutionalisation of healing 'traditions' considered national cultural heritage, such as shamanism and Traditional Mongolian Medicine. Such practices have garnered new legitimacy in public life, despite maintaining 'modes of relationality' reminiscent of the Soviet era. Newly associated with state regulation and the market economy, their practice in public garners criticism, claims of fraudulence and ineptitude. Turning attention to this now, similar criticism extends to biomedical practitioners, clinics and hospitals as well, linking 'alternative' and previously officially banned practices with more formal aspects of medical care.

Horse-trainer or Saviour? Heaven's Shaman or Business Shaman? Scepticism and the Register of Poison

As mentioned above, the past few decades have witnessed a drastic increase in non-biomedical practitioners, the presence of which pervades public life: courses to become a massage practitioner (*bariach*) and books that instruct 41 stone divination are readily available; in the warmer weather months, fortune-tellers line the street leading to Ulaanbaatar's central Buddhist temple; the clinics of energy healers and shamanic centres are scattered around the city. Accurate statistical measurements are difficult to track down. With respect to shamanism, for example, the National Statistical Office of Mongolia does not seem over-concerned with capturing an

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6 *Hümüüs öörsdöö aav deer ireed, 'tanai ohinoor bariuuliy' gej heldeg bolson*.

7 For other examples of the relation between medical pluralism and economic conditions in post-socialist settings, see Singh (2011) and Jasarevic (2011).

8 Approximately 1500 US$ at the time of fieldwork.

authentic number. Dubiously translating *böö mörgöl* into English as 'heathenism', the Office has listed the number of practitioners (under the heading 'Monks, Clergymen and Missionaries') in Ulaanbaatar at 18 in 2015, up from 3 in 2012 (National Statistics Office 2015: 161). One president of a shaman's union in Ulaanbaatar estimated there to be 10,000 shamans in Mongolia. However, a journalist who studied the topic intensively during the first decade of the 2000s estimated the current number to be 2000, stating that by quoting highly inflated numbers shamans hope to lend credence to their organisations.

With respect to shamanism, the sheer number practising now and perceived ubiquity of their presence were flagged as evidence of fraudulence. For example, an elderly man with the title 'living astrologist' (*amidiin zurhaich*), although people commonly refer to him as fortune-teller *(üzmerch*), astrologist (*zurhaich*) and 'fixer' (*zasalch*), told me: 'Dirtied shamans (*buzariin böö*) are not shamans. They just became shamans when they became sick. They are just searching for a profit. In one hundred years, five to ten real shamans are born. Maximum is ten. Minimum is five.' Along with ubiquity of shamanism as evidence of fraudulence, shamans' intentions and abilities were often called into question; terms like fake (*huramch*), fraudulent (*hudlaa*) or simply 'bad' (*muu*) were often used. An interlocutor estimated that 70–80 per cent of Mongolians these days actively avoid shamans because of the whole host of problems they have heard that they cause, of the 'black energy' *(har energi*) that follows them everywhere, as one practitioner of Buddhist medicine (*otoch*) put it. This becomes difficult when coerced to visit out of social obligation, especially that of family. Some go as rarely as possible, or only after being asked for by the ancestor spirits (*ongod*) themselves. In such a situation where scepticism prevails, it is typical to reveal as little information about oneself as possible. At other times the veil of social obligation is pierced and family members simply refuse to go. An interlocutor's father-in-law calls himself *dayanch*, which he defines as 'fighting with bad things […] [he] take[s] them into [himself] and destroy[s] them'. Some call him 'heaven's person' (*tengeriin hün*) as he claims to have a direct connection with heaven. He constantly sees things that shamans and lamas cannot, he said, and treats all kinds of illnesses and problems, such as patients unable to be healed at *Shar Had*, a common way to refer to the National Centre for Mental Health in Ulaanbaatar. My friend met her father-in-law only once, around the time of her wedding some 25 years ago. The fact that she still refuses to greet him, even for the lunar new year festival (*Tsagaan sar*), because of his spiritual practices causes her husband and family members no small amount of discomfort and grief.

Even shamans themselves are quick to cite the descending reputation of their practice. One shaman (*udgan*) explained to me that these days there are too many shamans, many of whom are practising incorrectly or for profit. These 'businessmen' and 'alcoholics' are not the real shamans, she said. Now people understand shamanism wrong: 'The meaning of the shaman is not to drink, not to smoke, not to get money, but to help people solve their problems without a high price', she told me. The term 'business shaman' (*biznes böö*) circulates these days, as opposed to

eight years ago when I first started researching shamanism (*böö mörgöl*) in Ulaanbaatar. A range of negative opinions were expressed: from shamans as a nuisance, beating their drums within shared apartment buildings late into the night, to people looking to make a profit; to the victims of a bad teacher, now made sickly, perhaps alcoholic, poisoned and actively poisoning others with whom they come in contact. The journalist mentioned above, who had a successful (if short) career researching shamanism, told me that even if he were still interested in the subject, newspapers refuse to print such stories. People are tired of hearing about it.

The accusations of falseness and corruption of shamans today coalesce in *zavsariin böö*, as Oyunaa, a fortune-teller who divines by match flame, told me. She said that shamans today do not derive their abilities from heaven's ancestor spirits (*tengeriin ongod*), but instead 'open the gate of dead people' by inviting 'the [souls of] dead people in *zavsart*[9] to enter them'. The number of people harmed or 'poisoned' by such shamans (*böögiin horlol hürsen hün*) has become a significant problem, she told me, and they come to her for help. Portraying a scenario reminiscent of youth from good homes getting mixed up with the wrong, degenerate crowd, Oyunaa went on to say:

> even though [these] people themselves have very good ancestry, they originated from very elite people, they entered shamanism and then damaged their inheritance. They make their heart-mind (*setgel sanaa*) disorderly. They destroy their own lives. They destroy things that are fine. They become superstitious. They cannot see correctly. They cannot treat things correctly.[10]

Scepticism was not just limited to shamans, but extended to biomedical practitioners in Mongolia. Criticisms were along similar lines: either the practitioners were suspected to be motivated only by financial gain, to be unskilled, or both. Over the course of the past two-and-a-half decades, trust in state-sponsored biomedical clinics in Mongolia has eroded incrementally. Horror stories of botched surgeries regularly circulate: a surgical sponge left inside the patient's chest cavity during heart surgery (it was not until he developed pneumonia and had an X-ray done that the blunder was discovered and the sponge removed); a surgeon removing the wrong kidney; a botched epidural during delivery; and now the right arm and leg of that University dean's body become incrementally shorter than those on the left by the passing year. Commonly heard are cases of misdiagnosis and the subsequent time and resources

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9 The realm between earth and sky where troubled souls and spirits are said to wander.

10 *Hümüüs öörsdöö ingeed mash sain mundag mundag elit garaltai ter odoo altan burgin gedeg shig mash sain yazguur ugsaatai hümüüs böö udgand orood al hediin udam ügsaagaa gemteegeed setgel sanaagaa samuuruulaad zöv zügeer baigaa yumiig öörsdoo busniuldag. Muhar süsegtei boldog. Zöv yumaa olj harj chadahgui baina. zöv yumandaa handaj chadahgui baina.*

lost trying this and then that treatment until the correct diagnosis is made and the condition properly medicated. People tend to blame poorly trained and underpaid doctors.[11] Interlocutors described the laborious process of receiving secondary or tertiary care, first obliged to deal with primary-care 'gate-keepers' (Janes & Hilliard 2008: 52), who one interlocutor characterised as 'several young women sitting around and painting their nails'. She had to bring her son three times to be seen for a sore throat before finally opting for private practice. The first two referrals led to specialists who prescribed the wrong medication, and the third state-sponsored referral recommended what ended up as being unnecessary removal of the boy's tonsils.

Upon further analysis, patients commonly questioned the rush to remove an organ without exploring other treatment options, especially if they doubted having received an accurate diagnosis from a biomedical practitioner. At a psammotherapy sanatorium in Dornogovi province, I spoke with one patient whose wife chose hot sand therapy in lieu of surgery: 'My wife's kidney got worse seven or eight years ago. The doctors said they couldn't heal her and they would remove the kidney.' They went to a sand sanatorium privately owned by a urologist from one of the state-sponsored clinics. Finding fault with sand cleanliness there, they tried another sanatorium in Övörkhangai province, finally finding 'Energy's Sand' centre in Dornogovi. 'Our family came here and my wife's health improved.' According to him, psammotherapy had restored the ailing kidney's size to normal, in large part due to the unique (*sonin*) and especially energetic (*energitei*) qualities of the sand.

At times private hospitals are not much better; only exorbitantly more expensive. In August 2016, a story circulated of a student who was home visiting family from where she typically lives and attends school in Switzerland. When she came down with acute back pain, her mother sent her to Intermed, one of the newest and reputable biomedical hospital in Ulaanbaatar, claiming to have been 'built under European hospital standards'.[12] Her mother was no exception, considering it, as an interlocutor relayed the story, 'a very good modern hospital'. The young woman went there, had tests done, and it was determined that she would need spinal surgery. While in surgery, the doctors made an error and she died. The mother, 'very offended', gave an interview to a newspaper to be publicly circulated.

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11 When I first started working in Mongolia in 2010, physicians employed in public hospitals earned 300,000 *tögrögs* per month. The average salary in 2015 among early career physicians, I was told, was 450–500,000 *tögrögs* per month. This can reach up to 700,000 with experience and/or additional educational degrees.

12 Intermed represents one of the most recently constructed hospitals, having opened in May 2014. It claims to be the result of the realization of social responsibility of Mongolia's 'three leading companies': MCS, Energy Resources and Shunkhlai Group (Intermed 2016). When I visited the website in 2016 it did not expound on what is meant by 'European hospital standards'.

Disillusionment with biomedical treatments in Mongolia drives those with the economic means to hospitals and clinics abroad, travelling to South Korea, China, Thailand, Turkey, Germany and so on to receive medical care.[13] Indeed, the founding doctor at one private clinic in Ulaanbaatar that combines Traditional Chinese and Mongolian Medicine with biomedicine described the rationale behind the hospital's establishment as a way to keep inside the nation's borders the money Mongolians would normally spend abroad on healthcare. When it is widely known that public hospitals endeavour to fill patient beds in order to increase their budget from the Ministry of Health for the following year, or that doctors working in public hospitals in the morning refer patients to their own private practices in the afternoon, it is difficult for many of the Mongolians I spoke with not to view such manoeuvres as exploitation of patient suffering.

With such competing opinions in circulation, and treatment options that can range drastically in price, practitioner and technique, the decision is often difficult to make. Should one go to Ochirvaani hospital, a well-established private clinic that blends Traditional Chinese Medicine and biomedicine for treatment of haemorrhoids, or to an elderly 'folk' healer (*domch*) who treats with hedgehog oil, draining the oil himself by suspending the skin over his kitchen stove which melts the layer of fat underneath, collecting the oil and then selling it for a few thousand *tögrög* from the shed in his front yard in one of Ulaanbaatar's *ger* districts? Critiques emerge for each: the first, exorbitantly expensive and still may not be effective; the second, no formal medical training and no standardisation of drug or administration.

Upon closer inspection, a similar strand runs through critiques of both biomedical and practitioners of 'alternative' medicine. Critiques often expressed idealised versions of (medical) care, reminiscent of health-care norms established during the state socialist period. This can be illustrated especially in the controversy surrounding Enkhbat, a practitioner of traditional medicine (*ardiin emch*). Nicknamed the 'sting doctor' (*hatgdag emch*), Enkhbat is a horse trainer by trade and healer by inheritance who practises out of his home in remote area of a central province. Perhaps 60 years old, he has been practising openly for 20 years, having taught himself to heal by blood-letting on snakes and horses from the age of 10. He has accumulated a fervent following in recent years, despite his lack of formal training: he typically treats from 60 to 300 patients per day who travel to his home from all over the country. People waiting for consultation or those involved in multi-day treatments and their families form encampments around his two-room brick building treatment centre. I was told that on any given summer day it resembles a festival (*naadam*) of sorts; hundreds flock to the steppe with their *ger* or tent. Patients

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[13] See the 2010 special issue of *Medical Anthropology* 29(4) for more on medical travel. The inequalities and failures within health systems of sending countries outlined by Whittaker *et al.* (2010) are particularly relevant to medical travel among Mongolians.

and their family members can be found relaxing or taking up casual sport, wrestling, volleyball, and so on, as they wait for treatment. If Enkhbat takes two or three days off to rest, his patient queue easily swells to over a thousand.

Enkhbat views the majority of illnesses as stemming from dirtiness that enters the body through the food one consumes. He 'heal[s] by the entire connected body',[14] which he does not view as separate from its surroundings, an outlook that resonates with many of the Mongolians with whom I spoke. Enkhbat determines what part of the body is dirtied (*bohirdson*) by checking the pulse at the wrist and heals by 'piercing and taking the dirtied blood' at the compromised organ or region, then giving injections there. He also administers oral medicine made from local plants.

Enkhbat has been criticised for what is a common point of contention over legitimacy and efficacy. Having heard of Enkhbat's popularity, Altangerel, a practitioner of TMM, published an article in an eminent newspaper[15] entitled 'Horse-trainer Enkhbat, or Saviour Enkhbat?' Although Altangerel says that he has no right to discourage a patient from seeking the kind of care he or she desires, he asks, 'What scientific basis underlies this man's powerful healing?' Having graduated from the Mongolian National University of Medical Sciences 23 years ago after undergoing seven years of educational training, Altangerel considers himself part of the development of TMM 'from the beginning'. He calls for the Ministry of Health to 'take appropriate steps' with such 'knaves' who have no certification nor standards by which to abide, as they threaten the 'progress of traditional medicine'. Altangerel takes umbrage with the fact that Enkhbat has no formal training, blood-lets from his home with his non-medically trained 'milk-maid' wife as nurse, and inappropriately treats various conditions: 'Any doctor would be surprised by a person who treats a viral infection by bloodletting'. He wonders why a doctor with over two decades of experience, two to three nurses with degrees in Traditional Medicine, and a three-room workspace inside a 'modern' building must seek proper permission, fulfil sanitary requirements, adequate working conditions and so on, while a person with no medical experience

> who has no basic sanitary requirements by the technical commission of health sector is able to continue his work? Are all these inspectors blind and deaf, or do they check only those people who have specific permission and ignore those who do not? Why are these governmental officials and parliamentary members promoting herdsmen and milk-maids, not the clinics that are helping the state-sponsored hospitals to overcome their workload?

[14] *Bi ugeljeer ni büten biyer ni emchildeg.*

[15] I do not reveal the source of the article, as Enkhbat's real name is printed. In furthering this, I have also concealed the identity of the author of this article.

A urologist from one of the state-sponsored clinics in Ulaanbaatar mentioned Enkhbat in respect of a recent patient with chronic kidney deficiency from Zavhan province. She treated her patient then sent him home, instructing that he would need to continue outpatient dialysis and should avoid traditional medicine: 'But this guy, what happened? He kept using different [traditional] things, became worse, we kept striving and saved him. Now he is healthy after a kidney transplant'.[16] She explained that one of the healers he visited was the sting doctor. In Enkhbat's absence, the patient had the sting doctor's younger brother—not a healer—administer the blood-letting. 'What are people thinking? [...] How will that person heal you?'[17] Slowly shaking her head from side to side, the urologist said, 'People visit shamans, lamas—whoever they wish—and use anything to heal. […] They go the wrong way and become worse. And they cause us [biomedical practitioners] to suffer'.[18]

Expressed here is the partial conflation of issues concerning legitimacy, efficacy and safety. Although the shift from focus on efficacy to safety has been noted elsewhere with respect to Asian medical systems,[19] the classification of a substance as 'toxic' or 'safe' depends on many factors (Gerke 2015: 381) and this ranges across biomedical and 'traditional' treatments. These critiques, taken together, also express an idealiszed version of medical care: it should take place in a 'modern' building. The practitioner ought to have formal medical training and the state should regulate their practice. Patients should follow a single treatment plan. There are templates that, when followed, ideally lead to efficacious medical care. Deviating from this course can result in anything from reduced efficacy to negative effects.

Ideally, too, patients receive a prescription before consuming pharmaceutical drugs. A pharmacist in central Ulaanbaatar explained the current unregulated distribution of pharmaceutical drugs in terms of changes to medical practices related to the politico-economic transition:

> Once the market economy began, everything became a little disorganized (*jaahan zambaraagui*). During the state socialist era, all drugs were sold by a doctor's

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16 *Nodoodoh chini yasan be yanz büriin yum khergelseer baigaa doshoo orson bid zütgeeseer baigaad avarsan. Odoo bol böör shiljuulj sulgaad saihan erüül yavj baigaa.*

17 *Yu bodood, yavaad baidag yum […] Yaj edgeh ve ter hün?*

18 *Düraaraa ochood iim tiim yum hergeleed böö lam ruu yavdag baidag […] buruu zamaar yavaad hünderdeg. Teged bid nariig zovooddog.*

19 Gerke (2015) raises the shift from efficacy to safety in contexts of anthropological approaches to Asian medical systems over the past few decades. As she notes, attention to safety reflects the increased global market for Tibetan Medicine and the 'scientific evidence' needed (Gerke 2013), which also relates to standardisation of safety. Gerke (2015: 376) intimates that, although notions of safety and efficacy cannot be completely teased apart, considering global and local contexts can help refine notions of each term.

> prescription (*emiin jor*). Now Mongolians always buy pharmaceutical drugs without a doctor's prescription. They buy antibiotics and so forth. When I ask, 'why weren't you seen by your doctor?' they say, 'I am busy. I have a lot of work.' It has become like this.

She explained that one reason people are not seen by their doctors is because their work hours overlap with those of doctors, and it can be difficult to take time off work. Even in the circumstance where leaving work to go to the hospital is possible, the doctor may or may not be there. If one's child is ill in the evening, the doctor has already left the hospital. So the parents call the ambulance, which may or may not come. Normally it comes, she said, but it takes a long time. Instead of dealing with this time-consuming chain of unpredictable events, people go straight to the pharmacy. They describe their symptoms and buy medicine, thereby attempting to address the problem expediently. At her pharmacy, approximately 70 per cent of pharmaceutical drugs are sold without a doctor's prescription, which is dangerous, she said, but ultimately the client is responsible for either consulting a doctor or educating themselves on the medication required.[20] The wider context of societal 'disorganisation' plays a crucial role in the unregulated consumption of pharmaceutical medication. However, as this pharmacist pointed out, the state used to take a more central role in pharmaceutical drug administration. State regulation of potentially toxic substances resonates with Soviet-era discourses, as the mass increase in usage of industrial poisons and the creation of highly toxic environments, for example in the production of mineral fertilisers and herbicides to increase agricultural production in the 1960s, corresponded with safety regulation of such substances. The first maximum permissible concentrations were set as early as 1922 (Roschin & Timofeevskaya 1975) and kept pace with the increasing production and synthesis of industrial toxins.

'Words can save and words can kill': Mutability of Care

Medicinal substances and treatments are dangerous for reasons apart from following a prescribed treatment plan. Upon closer inspection, toxicity engenders not a stable ontological status, but a shifting one: I heard of medicine and treatments that could easily become poisonous if given the wrong intention or administered by an unskilled practitioner. Healers themselves often cited the importance of good intentions, compassion and skill in guiding treatment along efficacious lines. As the above heading suggests (the quotation derives from an interview with an

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[20] This pharmacist's point here, that the responsibility has shifted from state to individual as self-regulated consumer amid growing health inequality, has also been argued for post-socialist Ukraine (Bazylevych 2014), Croatia (Dill & Zrinščak 2016), Poland (Watson 2013), China (Zhan 2013), Russia (Rivkin-Fish 2011) and Cuba (Brotherton 2012).

obstetrician and is discussed below), in this section I address the potential for a substance both to harm and to remedy, inherent to the Greek concept *pharmakon*.[21] Ordinary substances can transform into medicine, while medicine can become poison, which resonates with conceptions of toxicity in Tibetan medicine as well as other Asian medical systems (see Lai & Farquhar 2015). Dolma (2013: 106) describes the ability within Tibetan medicine to transform a potential toxin into a tonic as 'an invaluable skill based on the in-depth understanding of the characteristics of the various types of *duk*' or poison. The term *duk* is mulit-dimensional (Ibid., 110), ranging from mental poisons to inherent toxic nature of certain medical components, such as mercury. Tibetan pharmacological texts describe the intricate process of 'purifying' (*dülwa*) the poisonous, harmful aspects of a substance and enhancing the remedial ones. This requires great skill and knowledge on behalf of the practitioner. A distinguished scholar on the topic described to me the nuances involved: 'Take one plant. It can be medicinal on its own, or can be one ingredient in 30, 40, even 50 different medications. So this plant is combined with others what will it become? When you include a third plant it will tame/vanquish that plant's poison (*horiig darna*).' This is a formidable challenge for 'European' medicine (*euvropiin anagaah uhaan*) to understand, he said. The complexity of a medication with 57 different types of plants, for instance, is nuanced and dangerous, as the practitioner must know which combination of plants will target the illness, or in what combination a poisonous medication has been created.

Practitioners expressed the importance of skill and positive intention in guiding the treatment along efficacious lines. An elderly obstetrician explained to me that mutual trust must be established between the patient and doctor for healing to occur, regardless of the type of medicine practised. In order to do this, the practitioner must have correct intentionality, knowledge and skill: 'First, the doctor needs to have herself understood by her patient. Second, she needs to know well any type of illness.' In terms of the former, she must gain the patient's trust by rendering her caring heart-mind (*setgel*) transparent: 'In order to gain trust, I need words. I need good words. A doctor's words are one type of medicine for that patient.' Procuring trust is accomplished largely through performative measures, as 'one can understand *setgel* through character, appearance, eyes, movement, and voice nuance'. She elaborated:

> You can say one word in many nuanced ways. For example, 'okay' (*za*) expresses many different specific meanings. If you say *'za za'* twice, it means you are in a hurry. If you say *'zaaaaa'* you are accepting me nicely. The subtlety of words expresses a person's *setgel* […] when I speak with my patients, I express this through

[21] It is worth mentioning that the concept was somewhat recently popularised by Derrida (1981), who borrows the term from Plato's *Phaedrus* in order to analyse the practice of writing and meaning-making in Western philosophical traditions.

> my eyes, gestures, and so on. If I look badly, I have allowed my patient to understand that I am not paying attention to them. If I look well at them, the patient understands that I understand them. There is one look and gesture that expresses sympathy. I think that all of these are expressions of a person's *setgel*.[22]

Through such means, the practitioner–patient relationship can be guided towards one based upon trust: 'A doctor's spoken words must be orderly. One can kill only by words, one can save only by words.'

In addition to the importance of skill and good intention, I also heard of the importance of compassion. Bayaraa, an electrician by trade and Buddhist healer (*otoch*) by inheritance, is outspoken—chatty-sarcastic—on a good day, and on a bad day particularly cranky. One morning in June 2015 we were seated together inside the one-room building next to his home inside his fence (*hashaa*) where he consults with patients. His desk was so cluttered with mounds of pre-packaged envelopes containing medicine (*tan*) waiting for pick-up that he would have seemed far removed from his patients had he sat behind it. Instead he was seated adjacent, and between patient visits shared with me his motivations for practising medicine: 'My purpose for sitting here is to treat people that are suffering and ill by a compassionate *setgel*.' He lit a cigarette, leaned back in his chair and asked, 'Do you know what it means to be compassionate/merciful (*nigüülseh*)?' Without giving pause for answer, he continued:

> It means having a soft and loving *setgel*. […] A doctor must be a person who helps others by a compassionate/merciful *setgel*. The doctor's foundational purpose is this. By that meaning I try to foster relationships with tired and suffering people. If I have such a thought and such a *setgel*, I can help someone. If not, if I do this just to find money, I do not heal.[23]

Conclusion

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[22] *Neg üg bol chadna olon yanziin ayalguugaar helj bolno. Jishee ni 'za.' 'Za za' gedeg ügeer öör öör öngö garj bolno. 'Za za' gevel yaarch baina. 'Zaaaa' geh yum bol saihan hüleej avch baina. ügnii ayalguu hünii setgeliig ilerhiileg yum. […] Tiim uchraas bi övchtöndöö yarihdaa nüüdnii harts hödölgöön setgeliig ilerhiilne. Jishee ni, uhaandaa muuhai harah yum bol ene namaig töösöngui gej oilguulno. Chamaig sain haraad ingeh yum bol ene hün namaig oilgoh gej baina. Orovdoj baigaa harts baina, hödölgöön ene bügd hünii setgeliin ilerhiilel gej bi bodoj baina.*

[23] *Eneren hairlah zöölön setgel. Emch hün gedeg bol nigüülseh setgeleer niited tuslah setgeleer niited evteigden baih yostoi. Emch hünii ündsen yu ni bolbol tiim l baih yostoi. Ter utgaar yadarsan zovson hümüüst ter utgaar haritsahiig hicheej baigaa. Tiim bodol tiim setgel baij baij hünd tuslna. Tiimgui bol, möngö oloh gej hün emchildeggui.*

In this article I have argued that ethnographic characterisations of toxicity not only express scepticism with respect to healing and medical treatments, but toxicity's associations with Soviet-era toxicological studies and regulation and Buddhist medical discourses also mean that the term articulates the importance of state-sanctioned regulation and practitioner skill. Toxicity used in this context expresses the possibility of danger manifesting in various ways, from spiritual poisoning to wrongly made or misused medical substances. The prevalence of treatment failure points to the danger inherent in medical treatment; efficacy is not inevitable. The fragility of treatment is highlighted here, as are the multiple moving parts and multifarious actors—state, practitioner, patient, to name a few—involved in guiding the treatment in a successful direction. But even with all the pieces in the 'right' place—each actor following an idealised script as they 'ought' to—there is no guarantee. Wider societal disorganisation (*zambaargui baidal*) means that sometimes things just do not line up.

From patient and client perspective, the multiple authorities on health and wellbeing that exist in public life today can be difficult to navigate. This brings to light the frequent incommensurability of sources of legitimacy, whether they be healing abilities inherited or acquired by formal medical training, hand-made 'traditional' medicines (*tan, em tan*) or imported pharmaceutical drugs. Such varied sources of legitimacy articulate with other considerations, such as, for example, price and degree of treatment invasiveness. I have argued that one central source of legitimacy of healing 'traditions' has stemmed from the concept of national cultural heritage, the legacy of which derives from popular notions of Mongolian 'tradition' during state socialism, despite the official ban on such 'alternative' medical practices and healing remedies. Selective reconfiguration of Soviet medical infrastructure post 1990 has meant not only the inheritance of hospital buildings and sanatoria (*rashaan suvilal*), but also social norms concerning medical care, health and wellbeing. Soviet medicine, intended to revolutionise body and society, heavily relied on the collective fantasy of social progressivism. In the absence of the same state-promulgated vision, many criticise the 'postpresence' of the state (Dunn 2008: 254) in the reduced regulation of medical and health-related therapy.

Disaffiliating care from its typical associations with good intentions and positive outcomes creates space for ambivalences, inviting analytical attention to larger contexts of relationality. It has been my argument that attention to the materiality of medical infrastructure and of treatment failure affords insight into the messiness of meeting the needs of one's health and wellbeing in post-Soviet Mongolia: the laborious process of trying one therapy after another while one's condition worsens; the returning again and again to primary-care physicians for referral and the frustration of inefficiency and ineptitude; the question of who can heal the problem efficaciously and if that treatment will bankrupt you, or if an accurate diagnosis has been made to begin with.

References

Aulino, F. 2012. Sense and Sensibilities: The Practice of Care in Everyday Life in Northern Thailand. PhD dissertation, Harvard University.
---. 2016. Rituals of care for the elderly in northern Thailand: merit, morality, and the everyday of long-term care. *American Ethnologist* 43(1): 91–201.
Bashkuev, V. 2016. The role of medicine in the Soviet-Mongolian relations in the 1920s. *Tomsk State University Journal* 408. Online at: http://journals.tsu.ru//vestnik/en/&journal_page=archive&id=1435&article_id=30301 (accessed 29 August 2018).
Bazylevych, M. 2014. Disorder and civilization: the future(s) of Ukrainian medicine. *Czech Sociological Review* 50(6), 821–38.
Bernstein, F., C. Burton & D. Healey (eds.). 2010. *Soviet Medicine: Culture, practice and science.* DeKalb (IL): Northern Illinois University Press.
Brotherton, S.P. 2012. *Revolutionary Medicine: Health and the body in post-Soviet Cuba*. Durham/London: Duke University Press.
Bumochir, D. 2014. Institutionalization of Mongolian shamanism: from primitivism to civilization. *Asian Ethnicity* 15(4), 473–91.
Carroll, T., D. Jeevendrampillai & A. Parkhurst. 2018. Introduction: Towards a general theory of failure., in T. Carroll, D. Jeevendrampillai, A. Parkhurst & J. Shackelford (eds.), *The Material Culture of Failure: When things do wrong*: 1–20. London: Bloomsbury.
Collier, S. 2011. *Post-Soviet Social: Neoliberalism, social modernity and biopolitics.* Princeton/Oxford: Princeton University Press.
Derrida, J. 1981. Plato's pharmacy, in J. Derrida, *Dissemination* (trans. B. Johnson): 67-122. Chicago (IL): University of Chicago Press.
Dill, A. & S. Zrinščak. 2016. Bio-citizens or (yet another) third way? How NGOs negotiate state and individual responsibility for health in Croatia. *Anthropology of East Europe Review* 34(1): 6–24.
Dolma, S. 2013. Understanding ideas of toxicity in Tibetan medical processing of mercury. *Asian Medicine* 8: 106–19.
Dunn, E. 2008. Postsocialist spores: disease, bodies and the state in the Republic of Georgia. *American Ethnologist* 35(2), 243–58.
Garcelon, M. 1997. The shadow of the Leviathan: public and private in communist and post-communist society, in J. Weintraub & K. Kumar (eds.), *Public and Private in Thought and Practice: Perspectives on a grand dichotomy*: 303–32. Chicago (IL): University of Chicago Press.
Garcia, A. 2010. *The Pastoral Clinic: Addiction and dispossession along the Rio Grande*. Berkeley (CA): University of California Press.
Gerke, B. 2013. Buddhist healing and taming in Tibet: ritualized pharmacology, in M. Jerryson (ed.), *Oxford Handbook of Contemporary Buddhism*: 576-590. Oxford: Oxford University Press.
---. 2015. Moving from efficacy to safety: a changing focus in the study of Asian medical systems. (Special issue on *Medical Anthropology at Oxford: The First*

Decade and Beyond, eds. E. Hsu, S. Ulijaszek & C. Potter.) *Journal of the Anthropological Society of Oxford (JASO*) 7(3): 370–84.
Han, C. 2012. *Life in Debt: Times of care and violence in neoliberal Chile.* Berkeley (CA): University of California Press.
Henig, D. & N. Makovicky. 2017. *Economies of Favour After Socialism.* Oxford: Oxford University Press.
Intermed 2016. About us. Online at: www.intermed.mn (accessed 10 December 2016).
Janes, C. & C. Hilliard. 2008. Inventing tradition: Tibetan medicine in the post-socialist contexts of China and Mongolia, in L. Pordie (ed.), *Tibetan Medicine in the Contemporary World: Global politics of medical knowledge and practice*: 35–61. Abingdon: Routledge.
Jasarevic, L. 2011. Lucid dreaming: revisiting medical pluralism in postsocialist Bosnia. *Anthropology of East Europe Review* (29)1: 109–26.
Lai, L. & J. Farquhar. 2015. Nationality medicines in China: Iinstitutional rationality and healing charisma. *Comparative Studies in Society and History* 57(2): 381–406.
Larkin, B. 2013. The politics and poetics of infrastructure. *Annual Review of Anthropology* 42: 327–43.
Ledeneva, A. 1998. *Russia's Economy of Favours: Blat, networking and informal exchange*. Cambridge: Cambridge University Press.
Martin, T. 2001. *The Affirmative Action Empire: Nations and nationalism in the Soviet Union, 1923–1939.* Ithaca/London: Cornell University Press.
National Statistics Office. 2015. *Statistical Yearbook 2015*. Ulaanbaatar: National Statistics Office of Mongolia.
Pine, F. 2002. Retreat to the household? Gendered domains in post-socialist Poland, in C. Hann (ed.). *Post-socialism: Ideals, ideologies and practices in Eurasia*: 95–113. London: Routledge.
Read, R. & T. Thelen. 2007. Introduction: Social security and care after socialism: reconfigurations of public and private. *Focaal-European Journal of Anthropology* 50: 3–18.
Rivkin-Fish, M. 2005. *Women's Health in Post-Soviet Russia: The politics of intervention*. Bloomington (IN): Indiana University Press.
---. 2011. Health, gender and care work: productive sites for thinking anthropologically about the aftermaths of socialism. *Anthropology of East Europe Review* 29(1): 8–15.
Roschin, A.V. & L.A. Timofeevskaya. 1975. Chemical subtsances in the work environment: some comparative aspects of USSR and US hygienic standards. *Ambio* 4(1): 30–33.
Rossabi, M. 2005. *Modern Mongolia: From Khans to Commissars to Capitalists*. Berkeley(CA): University of California Press.
Singh, D. 2011. Attitudes and praxis of traditional forms of health care in a post-communist Romanian Romani community. *Anthropology of East Europe Review* (29)1, 127–40.

Smith, G., V. Law, A. Wilson, A. Bohr & E. Allworth. 1998. *Nation-building in the Post-Soviet Borderlands: The politics of national identity.* Cambridge: Cambridge University Press.

Starks, T. 2008. *The Body Soviet: Propaganda, hygiene, and the revolutionary state*. Madison (WI): University of Wisconsin Press.

Steiner-Khamsi, G. & I. Stolpe. 2006. *Educational Import: Local encounters with global forces in Mongolia.* New York (NY): Palgrave Macmillan.

Stevenson, L. 2014. *Life Beside Itself: Imagining care in the Canadian Arctic*. Oakland (CA): University of California Press.

Stoler, A. 2016. *Duress: Imperial durabilities in our times*. Durham (NC): Duke University Press.

Tsetsentsolmon, B. 2014. The 'gong beat' against the 'uncultured': contested notions of culture and civilization in Mongolia. *Asian Ethnicity* (15)4: 422–38.

Verdery, K. 1996. *What Was Socialism and What Comes Next?* Princeton (NJ): Princeton University Press.

Watson, P. 2013. Catastrophic citizenship and discourses of disguise: aspects of health care change in Poland, in P. Watson (ed.), *Health Care Reform and Globalization: The US, China and Europe in comparative perspective*: 118–38. Abingdon: Routledge.

Whittaker, A., L. Manderson & E. Cartwright. 2010. Patients without borders: understanding medical travel. *Medical Anthropology* 29(4): 336–43.

World Health Organization. 2012. Health service delivery profile: Mongolia. Online at: www.wpro.who.int/health_services/service_delivery_profile_mongolia.pdf (accessed 29 August 2018).

Zhan, M. 2013. Human oriented? Angels and monsters in China's health care reform in Poland, in P. Watson (ed.), *Health Care Reform and Globalization: The US, China and Europe in comparative perspective*: 71–92. Abingdon: Routledge.